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COMBINING ACUTE AND LONG-TERM CARE IN A CAPITATED MEDICAID PROGRAM: THE ARIZONA LONG-TERM CARE SYSTEM

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Introduction

One of the most pressing problems in the U.S. health care system today is the fragmentation of the delivery and financing systems. This is especially true for the aged and disabled. These individuals are normally eligible for Medicare, which covers most acute care medical services. Many also have private health insurance to pay for Medicare deductibles and copayments. Neither of these coverages, however, is widely applicable to the provision of long-term care services. Instead, as individuals' lives extend beyond their available resources, they often rely on Medicaid to pay for nursing home services.

For many years, health policy experts have argued that a less fragmented system would likely provide better care to everyone. However, the historical patterns of public and private insurance make combinations of the systems very difficult, if not impossible, in practice. The Arizona Long-Term Care System (ALTCS), an administratively separate component of the Arizona Health Care Cost Containment System (AHCCCS), Arizona's alternative Medicaid program, is an example of a program that attempts to reduce this fragmentation. Arizona receives federal funding for AHCCCS as a Health Care Financing Administration (HCFA) demonstration project.

ALTCS began in federal fiscal year (FY) 1989 as a statewide program to provide acute and long-term care services to Arizona's eligible long-term care beneficiaries. This paper describes eligibility for the ALTCS program, service coverage, revenue sources for program expenditures, the overall organization of the ALTCS system, and the ALTCS program contractors. It concludes with a discussion section.

Eligibility

As of January 1994, 18,136 individuals are enrolled in the ALTCS program. These are made up of 11,699 elderly and physically disabled (EPD)

beneficiaries and 6,437 beneficiaries who are mentally retarded or developmentally disabled (MR/DD).

ALTCS eligibility includes individuals with incomes up to 300% of the supplemental security income level ($1,338 per month in calendar year 1994) who are certified by a preadmission screening (PAS) instrument to be at risk of institutionalization. The PAS is administered by an ALTCS-employed nurse or social worker during a face-to-face interview with the applicant. Detailed information on referral sources, patient demographics, functional statuses, and medical statuses are collected at this time. Potential beneficiaries are also screened for mental illness and mental retardation. If possible mental illness or mental retardation is indicated, the case is referred to the Arizona Department of Health Services for a more thorough evaluation.

Coverage

ALTCS covers almost all traditional Medicaid program services. Benefits include inpatient hospital services, outpatient health services, physician services, laboratory services, radiology services, medical supplies, medical equipment, prosthetic devices, pharmacy, emergency services, emergency dental care, emergency ambulance and medically necessary transportation, medically necessary dentures, and podiatry services. Kidney, cornea, and bone transplants are covered for all members. Heart, liver, and autologous bone marrow transplants are covered for some categories of eligibles. As of January 1994, ALTCS provides the full range of Medicaid mental health services to all ALTCS beneficiaries except those 21-64 years of age who are not seriously mentally ill. This group's integration into full mental health coverage is expected by October 1994.

ALTCS also covers care in nursing facilities and intermediate care facilities for the mentally retarded (ICF/MRs), as well as home and community-based (HCB) services. HCB services covered by ALTCS are home health care, homemaker services, personal care, adult day health, hospice, respite care, transportation, home-delivered meals, and attendant care (including family

attendant care). In addition, ALTCS covers habilitation and day-care services for MR/DD beneficiaries. Adult day health, group respite services, and home-delivered meals are provided only for EPD beneficiaries.

Although HCB services are covered under the ALTCS program, there is a cap on the amount of home and community-based services (HCBS) use by the EPD population that will be reimbursed by the federal government. The cap was initially imposed by HCFA because of concern that the PAS tool would not effectively target people at risk of institutionalization, and thus would enable low-risk clients to receive HCB services. HCFA was also concerned that the unlimited availability of HCB services would encourage people with activity limitations who would otherwise be unwilling to be admitted to a nursing home to apply to the program (the "woodwork effect"). In the program's first year, the federal government limited reimbursement for HCB services to five percent of long-term care facility expenditures. Due to difficulty in implementing the five-percent expenditure ceiling, this was translated by ALTCS to a ten-percent limit on the percentage of EPD eligibles that could be enrolled in HCB services. Since then, the percentage of enrollees that can receive HCB services has increased steadily with each program year, and as of FY 94 was set at 35% of total EPD eligibles.

There is no cap on HCBS use for MR/DD beneficiaries. Before ALTCS, MR/DD treatment in Arizona emphasized home and community-based care and this emphasis has continued. Only a small percentage of current ALTCS MR/DD beneficiaries (i.e., less than 10%) are institutionalized.

Revenue Sources

The AHCCCS program, which includes both the acute care program and the ALTCS program, is funded by the federal government, the state, and the Arizona counties. In state fiscal year (SFY) 1992 (July 1992 - June 1993), the federal government contributed 51% to the overall AHCCCS budget, the state contributed 15%, and the Arizona counties contributed 35%. Since then, the percentage of revenue for the program that is contributed by the federal

government has increased. In SFY 93, the federal government's contribution increased to 56%, with the state contributing 12% and the counties contributing 32%. Budgeted expenditures for SFY 94 estimate the federal government will contribute 59%, the state 11%, and the counties 29% to the overall AHCCCS budget.

Organization of the System

Under the ALTCS model, the state contracts with one entity in each county to assume responsibility for providing services to EPD eligibles within the county. These entities are referred to as program contractors. The Arizona Department of Economic Security (DES), is required to serve as the program contractor for all MR/DD beneficiaries statewide. Program contractors receive a monthly capitation payment per enrollee from ALTCS. In turn, the contractors must arrange for the provision of a bundle of services that includes both long-term care and acute care services. As of January 1994, there are eight program contractors, seven of which provide services to EPD beneficiaries. Table 1 presents ALTCS EPD contractors and the counties they serve as of January 1994.

EPD contractors are paid a capitated amount per enrollee that differs by county but not by any other beneficiary characteristics. Medicare is the first payer for any service that it covers. Capitation payments are determined taking account of the expected Medicare coverage. FY 94 capitation rates range from a low of $1,776.64 [Ventana Health Systems (VHS) in Navajo County] to a high of $2,064.58 [Pima Health System (PHS) in Pima County]. As of January 1994, the DES capitation rate for FY 94 had not yet been agreed to and DES continues to use the FY 93 capitation rate of $2,511.87 per member per month. Enrollment by contractor is given in Table 2. Also included in Table 2 are 161 enrollees who are handled by AHCCCS directly and 427 American Indian enrollees who receive services from their tribe providers.

Capitation rates for the EPD contractors are set through a bidding process. In the most recent bid year (FY 94), bids were evaluated by

Table 1

ALTCS EPD PROGRAM CONTRACTORS AND THE COUNTIES THEY SERVE
AS OF JANUARY 1994

Program Contractor	Counties
Arizona Physicians Independent Physicians' Association	Coconino Yuma
Cochise County Department of Health Services	Cochise
Maricopa Managed Care System	Maricopa
Pima Health System	Pima
Pinal County Long-Term Care	Pinal
Ventana Health Systems	Apache Gila Graham Greenlee La Paz Mohave Navajo Santa Cruz
Yavapai County Long-Term Care	Yavapai

Table 2

NUMBER AND PERCENT OF LONG-TERM CARE ENROLLEES
BY CONTRACTOR AS OF JANUARY 1, 1994

	Number	Percent
AHCCCS Fee-For-Service	161	0.9
Arizona Physicians Independent Physicians' Association	380	2.1
Cochise County Department of Health Services	347	1.9
Department of Economic Security	6,437	35.5
Indian Tribe Providers*	427	2.4
Maricopa Managed Care System	6,723	37.1
Pima Health System	1,874	10.3
Pinal County Long-Term Care	422	2.3
Ventana Health Systems	893	4.9
Yavapai County Long-Term Care	472	2.6
All Enrollees	18,136	100.0

Source: AHCCCS, Enrollment/Eligibility Status Report, January 1, 1994

* This includes 253 American Indian beneficiaries enrolled with Navajo Nation, 72 with White Mountain Apache Tribe, 47 with Gila River Tribe, 40 with San Carlos Apache Tribe, and 15 with Pasqua Yaqui Tribe.

disaggregating them into 11 cost components: institutional, Medicare/third party liability payments, share of cost payments, capitation lag factor, HCB services, mix of HCB and institutional services, mental health, acute care, case management, administration, and profit. Acceptable bid ranges for each of these components were developed by ALTCS. If a final bid was within the acceptable range for a given component, the contractor was given the bid price for that component. If it was above the rate range, the contract was awarded at the midpoint of the range for that component. Bids that fell below the rate range for a component were given the bottom of the rate range for that component. The 11 components were then added to derive the capitation rate paid to the contractor.

Since ALTCS' inception, Arizona's two urban counties — Maricopa and Pima counties — have been required by law to serve as program contractors. In the remaining 13 counties, the county governments are given the right of first refusal to be the program contractor in their respective county. If a county does not elect to exercise its right of first refusal, that county is opened up for competitive bid to private entities. If no qualified bidders are found at an acceptable capitation rate, ALTCS manages the county through a fee-for-service network.

There has been increased interest in the program on the part of private contractors and the counties as the ALTCS program has matured. In FY 94, two new counties elected to come into the program, thereby increasing the number of participating counties from three to five. Five private entities bid for ALTCS contracts in the ten remaining counties. For the first time since the ALTCS program's inception, there was competition in the bidding process; eight of the ten counties had at least two bidders and three counties had three bidders. This was also the first year in which there was an acceptable bidder for every county.

Counties' increased participation is largely a result of their interest in retaining control of the program's operation, given the large financial contributions that they are required to make to the ALTCS budget. Meanwhile, private entities have been lobbying the legislature to open all counties to

competitive bid, including those in which the contractor is mandated to participate (i.e., Maricopa and Pima counties).

Program Contractors

At the center of the ALTCS program are the program contractors that receive prepaid capitation payments in return for assuming responsibility for the provision of acute and long-term care services to program beneficiaries. Theoretically, the program contractor model creates incentives for efficiency that are not present in the fee-for-service delivery model. For ALTCS to be successful, contractors must have efficient methods to subcontract for the actual provision of services, as well as to monitor the access to and utilization of services delivered. They must also accomplish these activities within their defined capitation payments. Below we provide information on the characteristics of the program contractors, their methods of subcontracting, their monitoring responsibilities, and their ability to live within the capitation-defined budgets.

Contractor Characteristics

As of January 1994, there are eight ALTCS program contractors — five county-based contractors, two private contractors, and one state agency (DES). The program contractors vary across a number of dimensions. Table 3 presents information on a number of program contractor characteristics, including the year that they first became contractors, the number of ALTCS beneficiaries and counties served, profit status, and affiliations with AHCCCS acute care plans and Medicare health maintenance organizations (HMOs).

Four of the eight program contractors have participated in the ALTCS program since its inception. Three of these are government entities that are mandated by law to be program contractors [DES, Maricopa Managed Care System (MMCS), and PHS], and the fourth is a private entity (VHS). At the beginning of FY 91, they were joined by one private and one public entity, Arizona

Table 3

PROGRAM CONTRACTOR CHARACTERISTICS AS OF
JANUARY 1, 1994, BY TYPE OF BENEFICIARY

	Starting Date	Enrollment	Number of Counties	Profit Status	AHCCCS Plan Affiliation	Medicare HMO*
EPD Beneficiaries						
County Contractors						
CCDHS	11/93	347	1	GOVT	NO	NO
MMCS	01/89	6,723	1	GOVT	YES	YES
PHS	01/89	1,874	1	GOVT	YES	NO
PCLTC	10/90	422	1	GOVT	NO	NO
YCLTC	10/93	472	1	GOVT	NO	NO
Private Contractors						
APIPA	10/90	380	2	NFP	YES	NO
VHS	01/89	893	8	FP	YES	NO
MR/DD Beneficiaries						
State Agency						
DES	12/88	6,437	15	GOVT	NO	NO

* Medicare HMO refers to those HMOs that, pursuant to the Tax Equity and Fiscal Responsibility Act, enroll Medicare beneficiaries in exchange for a monthly prospective payment from HCFA.

FP: For Profit
GOVT: Government
NFP: Not for Profit

Physicians Independent Physicians' Association (APIPA) and Pinal County Long-Term Care (PCLTC), respectively. The two newest contractors, Cochise County Department of Health Services (CCDHS) and Yavapai County Long-Term Care (YCLTC), began participating in FY 94. Both of these contractors are county-based. Also in FY 94, one of the two original private contractors, Comprehensive AHCCCS Plan (CAP), terminated its affiliation with the ALTCS program.

There is wide variation in the number of ALTCS beneficiaries enrolled with each contractor. MMCS is the largest contractor, serving 6,723 EPD eligibles in Maricopa County. This is followed by DES, which serves 6,437 MR/DD eligibles in all of Arizona's 15 counties. PHS is the only other contractor that has more than 1,000 enrollees. VHS, the program's largest private contractor, has 893 EPD eligibles in eight rural counties. The smallest ALTCS contractor is CCDHS with an enrollment of 347.

The vast majority of enrollees (93%) are served by government entities. Of the two contractors that are not government-based, one is a for-profit entity (VHS) and the other is not-for-profit (APIPA).

One-half of the ALTCS contractors have a close affiliation with an acute care plan that contracts with the state to serve AHCCCS acute care eligibles. These include the contractors in Arizona's two urban counties and the two private contractors. As of January 1994, only MMCS operates a Medicare HMO, although several contractors report that they may develop one in the future. This is a relatively new undertaking for MMCS; the Medicare HMO began operating in November 1993.

Subcontracting

Program contractors use a variety of methods to procure providers. The primary methods used by each contractor for procuring nursing facilities, HCB services, and physician services are presented in Table 4.

Table 4

PRIMARY METHOD OF PROVIDER PROCUREMENT FOR TYPES OF SERVICE,
BY CONTRACTOR AND TYPE OF BENEFICIARY, FY 94

	Nursing Facilities	HCBS	Primary Care Physicians		Specialists
			NH Population	HCBS Population	
EPD Beneficiaries					
County Contractors					
CCDHS	Competitive Bid	Competitive Bid	Competitive Bid	Competitive Bid	Competitive Bid
MMCS	Competitive Bid	Competitive Bid	Negotiation	Interagency	Negotiation
PHS	Competitive Bid	Competitive Bid	Competitive Bid	Interagency	Competitive Bid
PCLTC	Competitive Bid	Competitive Bid	Competitive Bid	Competitive Bid	Competitive Bid
YCLTC	Competitive Bid	Competitive Bid	Negotiation	Negotiation	Negotiation
Private Contractors					
APIPA	Negotiation	Negotiation	Negotiation	Negotiation	Negotiation
VHS	Negotiation	Negotiation	Negotiation	Negotiation	Negotiation
MR/DD Beneficiaries					
State Agency					
DES	Competitive Bid	Competitive Bid	Competitive Bid	Competitive Bid	Competitive Bid

The county contractors and DES are required to follow procurement rules for government entities as specified by state law and by their own counties. These procurement codes require that they use a competitive bid process for selecting most service providers. The major exceptions to this requirement are for contracting with other entities within the county government, for services for which there is only one vendor in the county, and, in some counties, for professional services.

As shown in Table 4, all five county-based contractors and DES procure nursing facility and HCB services through an official competitive bid process, whereas private contractors negotiate directly for these services. DES uses a competitive bid process to select ICF/MRs as well.

A program contractor has two major options for establishing an acute care network. It may contract directly with providers for each covered service (e.g., primary care, specialist services, transportation, laboratory, etc.) or may subcontract with one entity that in turn will set up a comprehensive acute care network. A program contractor that is affiliated with an acute care plan has the additional option of arranging with its health plan to provide these services.

None of the contractors that operates an AHCCCS acute care plan (APIPA, MMCS, PHS, and VHS) arranges directly with its affiliated plan to provide the full range of acute care services to ALTCS beneficiaries, although it may rely on the same provider network for certain services. The two private contractors, APIPA and VHS, negotiate with physicians in their AHCCCS acute care network to provide services to ALTCS beneficiaries in their respective counties. MMCS negotiates contracts for the provision of primary care physician (PCP) services to nursing home residents and for specialty services to nursing home and HCBS beneficiaries. PCPs for the HCBS population are obtained through an interagency agreement. Prior to July 1993, PHS had a waiver that allowed it to directly procure professional services but this exemption has been discontinued. PHS' contracts were negotiated before the exemption expired, but most future contracts will be competitively bid. PCP

services for HCBS clients will be obtained through an interagency agreement as has been done in the past.

Of the four remaining contractors, all of which are government entities, only PCLTC establishes its own acute care network via competitive bid. The two new county contractors (CCDHS and YCLTC) each initially issued a request for proposal seeking an entity to provide acute care services to its ALTCS beneficiaries. CCDHS had several responses to its solicitation. The winning response came from Intergroup Health Care Corporation, a for-profit corporation based in Tucson. YCLTC's solicitation did not attract any qualified bidders, so it set up its own PCP and specialty networks. YCLTC, which is exempt from bidding for professional services, negotiated contractual arrangements with the majority of the PCPs who had contracted with VHS (the prior ALTCS contractor in Yavapai County).

DES uses a competitive bid process to select health plans in each county to provide acute care services to MR/DD beneficiaries. In counties without contracted health plans, DES manages a fee-for-service network of providers. As of January 1994, DES contracts with three acute care health plans and only one county is served by its fee-for-service network.

Payment arrangements for nursing home care, HCB services, and physician services can also vary by contractor. These arrangements are presented in Table 5. Providers are required to bill Medicare for Medicare covered services before submitting claims to the program contractors.

All of the program contractors pay nursing homes a per diem amount based on the client's level of care, of which there are three plus specialty care. ICF/MRs are also paid on a per diem basis. HCB services are currently reimbursed on a per unit basis by all of the program contractors, although in past years, HCB services provided to ALTCS beneficiaries in Yuma County were reimbursed by APIPA on a capitation basis.

The methodology used to reimburse for PCP services varies across the program contractors. Some contractors have adopted capitated approaches while

Table 5

PRIMARY METHOD OF PROVIDER REIMBURSEMENT FOR TYPES OF SERVICE,
BY CONTRACTOR AND TYPE OF BENEFICIARY, FY 94

	Nursing Facilities	HCBS	Primary Care Physicians		Specialists
			NH Population	HCBS Population	
EPD Beneficiaries					
County Contractors					
CCDHS	Per Day	Per Unit	Capitation	Capitation	Capitation
MMCS	Per Day	Per Unit	Per Hour	Fee-for-Service	Fee-for-Service
PHS	Per Day	Per Unit	Flat rate	Capitation and Fee-for-Service	Fee-for-Service
PCLTC	Per Day	Per Unit	Capitation	Capitation	Fee-for-Service
YCLTC	Per Day	Per Unit	Capitation	Capitation	Fee-for-Service
Private Contractors					
APIPA	Per Day	Per Unit	Capitation or Fee-for-Service	Capitation or Fee-for-Service	Fee-for-Service
VHS	Per Day	Per Unit	Capitation or Fee-for-Service	Capitation or Fee-for-Service	Fee-for-Service
MR/DD Beneficiaries					
State Agency					
DES	Per Day	Per Unit	Capitation	Capitation	Capitation

others pay hourly or flat rates. Among those who reimburse PCPs on a capitated basis, there are differences in the structures used to determine the payment amount. Virtually all of the program contractors pay for specialist services on a fee-for-service basis, except those that have a subcontracted acute care arrangement (CCDHS and DES).

Several contractors have set up capitation arrangements to pay PCPs who serve ALTCS beneficiaries. PCPs who contract with YCLTC receive a capitation payment with graduated reimbursement depending on enrollment (i.e., the more ALTCS patients a physician enrolls, the more the reimbursement per person). At PCLTC, PCPs receive a capitation payment each month per enrolled member that varies by whether or not the beneficiary has Medicare coverage. The majority of PCPs at APIPA and VHS are paid on a capitated basis with remaining PCPs receiving payment on a fee-for-service basis.

CCDHS and DES incorporate payment for physician services into the monthly capitation paid to their subcontracted acute care plans. CCDHS' subcontractor transfers some of this risk to its providers by capitating most of the PCPs with whom it contracts. Health plans providing acute care services to MR/DD beneficiaries receive a capitation payment that varies by whether or not a client has Medicare coverage. Rates paid by DES also are adjusted to reflect differential cost and utilization patterns among Maricopa, Pima, Pinal, and rural counties.

Providers of PCP services to PHS' nursing home beneficiaries are paid a flat rate per month. The majority of HCBS clients receive primary care through a clinic at Kino Community Hospital, the county-owned hospital. In return for providing professional services, the physician who staffs this clinic receives a monthly capitation payment per enrollee. PHS also pays two facility fees for services provided at this clinic: a monthly capitation payment and a fee-for-service payment for facility charges associated with each patient visit.

Of all the program contractors, MMCS relies most heavily on fee-for-service reimbursement to pay physicians. MMCS physicians who provide primary

care services to beneficiaries in nursing homes are paid an hourly rate. Primary care provided to HCBS clients as well as specialty services provided to all ALTCS beneficiaries are paid for on a fee-for-service basis.

On March 1, 1993, ALTCS implemented a cost-based per diem hospital reimbursement system. Under this system, hospitals cannot be reimbursed more than the AHCCCS tiered per diem rate for inpatient hospital stays. All of the program contractors have adopted this methodology and pay hospitals the AHCCCS tiered per diem rate for service provided to ALTCS beneficiaries.

Monitoring

Contractors also have responsibilities to manage the care delivered to their program beneficiaries. All beneficiaries are assigned a contractor-employed case manager. The case manager is responsible for determining whether to place the beneficiary in home or institutional care. If the beneficiary is institutionalized, the case manager determines the appropriate facility placement. If they are to remain at home, the case manager authorizes appropriate home care services in the individual's care management plan.

Contractors are also responsible for the development of HCBS provider networks, setting up quality assurance activities, having a functioning grievance and appeals process, and monitoring the utilization of services.

Financial Experience

ALTCS program contractors are required to submit monthly, quarterly, and annual cost reports, including balance sheets and income statements. Data presented in Tables 6-8 are from cost reports submitted to ALTCS by the seven entities that served as program contractors in FY 91 and FY 92. As can be seen in Table 6, PHS was the only contractor that reported losses in FY 91. Of those reporting income in FY 91, four of the five EPD contractors had net

Table 6

NET INCOME PER MEMBER PER MONTH
BY CONTRACTOR AND FISCAL YEAR

	FY 91	FY 92
EPD Contractors	$ 22.25	$ 5.70
Arizona Physicians Independent Physicians' Association	196.86	290.39
Comprehensive AHCCCS Plan	235.73	183.90
Maricopa Managed Care System	28.59	(26.47)
Pima Health System	(147.99)	(38.51)
Pinal County Long-Term Care	162.70	180.57
Ventana Health Systems	133.92	77.24
MR/DD Contractor		
Department of Economic Security	14.23	(83.57)

Source: Annual Audited Reports and Quarterly Financial Reports submitted to the AHCCCS Administration by the participating long-term care contractors.

Table 7

ADMINISTRATIVE COSTS PER MEMBER PER MONTH
BY CONTRACTOR AND FISCAL YEAR

	FY 91	FY 92
EPD Contractors	$161.12	$180.43
Arizona Physicians Independent Physicians' Association	182.70	164.17
Comprehensive AHCCCS Plan	129.59	189.92
Maricopa Managed Care System	158.54	181.23
Pima Health System	174.94	195.82
Pinal County Long-Term Care	135.96	159.07
Ventana Health Systems	156.78	166.05
MR/DD Contractor		
Department of Economic Security	417.48	415.12

Source: Annual Audited Reports and Quarterly Financial Reports submitted to the AHCCCS Administration by the participating long-term care contractors.

Table 8

CASE MANAGEMENT COSTS PER MEMBER PER MONTH
BY CONTRACTOR AND FISCAL YEAR

	FY 91	FY 92
EPD Contractors	$ 48.50	$ 48.53
Arizona Physicians Independent Physicians' Association	49.35	50.48
Comprehensive AHCCCS Plan	45.20	47.46
Maricopa Managed Care System	52.80	48.30
Pima Health System	41.10	44.49
Pinal County Long-Term Care	54.64	48.92
Ventana Health Systems	40.51	53.74
MR/DD Contractor		
Department of Economic Security	122.32	118.27

Source: Annual Audited Reports and Quarterly Financial Reports submitted to the AHCCCS Administration by the participating long-term care contractors.

incomes that were over $130 per member per month. CAP's net income exceeded $225 per member per month. DES, the MR/DD contractor, reported an excess of revenues over expenses of $14 per member per month.

In FY 92, the two largest EPD contractors, MMCS and PHS, both reported losses. The four remaining EPD contractors all reported income with three of the four reporting net income in excess of $180 per member per month. At $290 per member per month, APIPA's net income was the largest in the program. DES reported a loss of $84 per member per month for FY 92, a decline from its previous year's estimated income of $14 per member per month.

Table 7 shows the administrative costs (that is, all costs that are not for the provision of medical services) reported by the ALTCS contractors for FY 91 and FY 92 in the financial reports required by the program. Administrative costs are for activities such as case management, data processing, compensation, management fees, insurance, interest, rent, and depreciation. These costs averaged $161 per member per month for EPD contractors in FY 91 and ranged from a low of $130 for CAP, the smallest contractor, to a high of $183 for APIPA, a new private contractor. In FY 92, average administrative cost for EPD contractors was $184. The smallest administrative cost per member per month was $159 (PCLTC) and the largest was $201 (PHS). DES, the program contractor for MR/DD beneficiaries, reported significantly larger administrative costs than the EPD contractors in both years. They reported average costs per member per month of $417 in FY 91 and $415 in FY 92.

Table 8 shows administrative costs for case management per member per month for FY 91 and FY 92. EPD contractors had an average cost of $49 in both years. The rate for DES was $122 in FY 91 and $118 in FY 92. Because case management costs would be expected to be larger for beneficiaries who receive HCB services rather than institutional care, case management costs would be expected to be larger for DES than for the EPD contractors given that DES places almost all of its beneficiaries in HCB care. Thus, some of the difference in administrative cost between DES and the EPD contractors is due to DES' larger expenses for case management.

Summary and Discussion

The ALTCS program serves as a functioning model for the integration of acute and long-term care services for long-term beneficiaries at risk of institutionalization. Eligibility and coverage mirror traditional Medicaid programs with waivers for expansion of home and community-based services.

To become eligible for ALTCS, individuals must pass both a financial and medical screen. Medical eligibility is determined through the use of a PAS instrument applied by the ALTCS program staff. Beneficiaries who are found to be eligible are assigned to program contractors. Upon enrollment, a case manager who is employed by the program contractor formulates a care plan for each beneficiary. The care plan can call for home care or institutional care. Within each of these placement options different services or levels of treatment are approved for payment.

ALTCS has contracts with eight entities — five county-based entities, two private entities, and one state agency — to serve as program contractors. As of January 1994, more than 90% of all ALTCS beneficiaries are enrolled with a public-sector based contractor.

Constraints in the county and state procurement codes necessitate that public-sector based contractors use competitive bidding to procure most services. In contrast, private contractors are free to negotiate directly with all potential providers. The majority of program contractors contract separately for each ALTCS covered service. Two contractors, however, subcontract with a single entity to provide the full range of acute care services to program beneficiaries.

Program contractors have to some extent adopted competitive, managed care approaches to pay their providers. This is most evident in the reimbursement of PCPs, for which most contractors have instituted capitated arrangements. In most cases, however, non-PCP providers are paid using traditional methods. Thus, with the exception of primary care, what sets this

Medicaid program apart from traditional ones is the presence of an intermediary, the program contractor, that manages payments within an overall budget.

Program contractors are capitated for acute and long-term care services. Medicare is the first payer for any service it covers and the capitation payment is determined taking account of expected Medicare coverage. The capitation payments define a budget within which most of the contractors have been able to operate. Only the mandatory county contractors have reported losses. In FY 92, net income averaged $6 per member per month across all EPD contractors. If the two mandatory counties are excluded, net income ranges from a profit of $77 per member per month to $290 per member per month.

Administrative costs at the contractor level are substantial, in FY 92 averaging $180 per member per month for EPD contractors (with a range of $159 - $196) and $415 per member per month for DES. A large component of these costs is for case management. Approximately $50 per member per month is spent for case management by the EPD contractors and $120 per member per month by DES.

This paper has laid out the details of the unique features of the ALTCS program. As an integrated long-term care program, it has great potential to rationalize the financing and delivery of care for those individuals in need of long-term care. Other evaluation reports and papers will investigate various facets of its success.

PUBLICATIONS ON THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM AND THE ARIZONA LONG-TERM CARE SYSTEM

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